PAYMENT POLICIES

It is important to understand that whether or not you have insurance, the fee for any service provided is your responsibility. If you have dental insurance, we will help you estimate your benefits. There are many factors that can impact your estimate. These include, but are not limited to, services performed at another office, treatment plan changes, benefit exhaustion, insurance fee schedules, or plan termination.

Payment is due at each visit with the total estimated remaining balance due by completion of treatment. Any balance remaining after insurance processing, whether denied, partially paid, or changed in any way, is the full responsibility of the patient/parent.

My signature below certifies that I understand and agree to pay **"Atkinson Dental Health Center"** the total amount due for any and all services rendered.

Signature: ______________________________________ **Date**_____________________________

INSURANCE

Dental Insurance? ◯ Yes ◯ No (if yes, please complete below.) **If there is more than one insurance, please ask for an additional form**

Patient Name:____________________________ DOB:______________ SS#: _____________________

Subscriber Name: _________________________ DOB:______________ SS#: ______________________

Subscriber Place of Employment: ____

Name of Dental Insurance Carrier: ____

Insurance Billing Address P.O. Box # or Street: ____

Town/City: _______________________ State: _______ Zip: _______ Phone #: ___________________

ID#: ____ Group #: ________________________________

Patient/Guardian Signature for Assignment of Benefits: _________________________________

Your signature here authorizes your insurance company to send payments directly to the provider of dental services.

CONSENT TO TREATMENT

I consent to the performance of dental services deemed necessary or advisable. Further, I certify that the information provided on this form is accurate and correct to the best of my knowledge.

Signature of Patient/Guardian: _________________________________ **Date:** _________________